PLAN DOCUMENT,
SUMMARY PLAN DESCRIPTION
AND
ADMINISTRATIVE WRAPPER

HANFORD RETIREE
WELFARE BENEFIT PLANS

Offered under the
HANFORD EMPLOYEE
WELFARE TRUST (HEWT)

DATED NOVEMBER 1, 2004

This plan document and summary plan description contains information the Plan Administrator is required to provide to you under federal law.

TABLE OF CONTENTS

Page

INTRODUCTION

This document is the formal plan document and summary plan description under which the welfare benefit plans available to retirees and their dependents (the "Plans") listed in Attachment A (the "Plans Chart") and offered under the Hanford Employee Welfare Trust (the "Trust") are administered. A separate document governs benefits provided to active employees and their dependents. As used in this document, "we," "us" and "our" refers to the Plan Administrator. "You" and "your" are referring to covered retirees and their dependents.

This document along with the other summary plan descriptions (SPDs)contain important information about your rights and obligations under federal law and under the Plans and the procedures you need to follow if you have questions about your benefits or if you disagree with a decision on your claim for benefits.

Benefits under the Plans are provided through the Trust. The Trust has been adopted by the employers listed on Attachment B (the "Sponsors Chart"). They are the Sponsors of the Plans. You are receiving this document because your former employer (or its predecessor) is one of the Sponsors of the Plans.

The Sponsors have appointed the Board of Trustees of the Trust as the Plan Administrator of the Plans. Fluor Hanford, Inc. ("Fluor") has responsibility under their Contract with the United States Department of Energy (the "DOE") for administering the Plans. The Board of Trustees has delegated certain administrative responsibilities to Fluor. Other entities are involved in the insurance and/or administration of the Plans as well. These are described in the Plans Chart.

You have received, or will receive, additional summaries or summary plan descriptions ("SPDs") governing the Plans in which you are eligible to participate. Contact Fluor Hanford, Inc., Attn: Benefits Administration (H2-23), P.O. Box 1000, Richland, Washington 99352 for additional information, as well as the current plan rate structures. The SPDs provide detailed information about the benefits you are entitled to and steps you must take to obtain those benefits. The SPDs are incorporated into this document by this reference. If there are conflicts between the language of the SPDs and this document, the terms of this document control. You may also receive official additional plan documents, insurance contracts, trust agreements and other documents which legally govern the operation of the Plans (the "Plan Documents"). This document is intended to be read in conjunction with and as a supplement to the SPDs and other Plan Documents, except as otherwise expressly provided.

DESCRIPTION OF THE PLANS

The names of the Plans (and, if different, the name by which the Plans are commonly known), Plan number assigned by the Board of Trustees, and the types of the Plans (medical, and life insurance) are described in the Plans Chart.

The following benefit programs are available to retirees as of November 1, 2004. Refer to each plan's Summary Plan Description for details.

Medical:

Retirees who are not yet eligible for Medicare by virtue of age (i.e., under age 65) can choose from the following three plans for themselves and their eligible dependents. Plans and rates are subject to change.

1. **"Options" Preferred Provider Option (PPO) Plan (Claims administration by United Healthcare)**

   This plan covers most expenses for health care services from any qualified provider. The plan pays a majority of the incurred medical expenses after an annual deductible has been met. Retirees electing this plan can receive medical care from any qualified provider. Under the PPO, the reimbursement is greater if care is received from one of the network providers nationwide who are participants in the PPO.

2. **Group Health Cooperative (GH) Health Maintenance Organization (HMO)**

   This is a managed care plan where retirees and dependents select a GH contracted primary care physician who provides their care, referring them to other GH contracted providers and facilities when needed. Refer to the GH Certificate of Coverage for plan provisions. This plan is available only to retirees residing in a GH service area.

3. **Group Health Cooperative (GH) Options Point of Service (POS) Plan**

   This plan offers members a combination of in- network managed services found in the GH HMO and "out-of-network" services which can be from any qualified provider. Contact GH as to availability of coverage outside of GH service area and the Certificate of Coverage plan provisions.

Retirees who are age 65 and older (eligible for Medicare) can choose from the following plans for themselves and eligible dependents. For retirees and for dependents enrolled for Medicare, these plans are *secondary* to Medicare A and B:

1. **Medical Plan for Medicare-Eligible Retirees (Claims administration by United Healthcare).**

   This self-insured plan covers expenses for health care services from any qualified provider. The plan pays a portion of the incurred medical expenses after an annual deductible has been met. Retirees electing this plan can receive medical care from any qualified provider.

2. **Group Health Cooperative (GH) Health Maintenance Organization (HMO) for Medicare-Eligible Retirees (similar to the GH HMO plan for retirees under age 65, described in #2 above).**

3. **Group Health Cooperative (GH) Options Point of Service (POS) Plan for Medicare-Eligible Retirees (similar to the GH Options plan for retirees under age 65, described in #3 above).**

Life Insurances:

- Basic Life Insurance /AD&D

  Retirees Under age 65: coverage of up to two times the retirees base salary rate plus AD&D coverage at the time of retirement is available on a shared cost basis.

  Retirees over age 65: coverage of up to one-half times the retiree's base salary for Basic Life at the time of retirement is available on an employer-paid basis.

- Dependent Life Insurance

  Retirees under age 65 may continue dependent life insurance for spouse and dependent children.

PLAN SPONSORS

The names of the Sponsors, their addresses and their Employer Identification Numbers ("EINs") assigned by the Internal Revenue Service are described in the Sponsors Chart. In addition, participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer is a Sponsor of the Plan and, if the employer is a Plan Sponsor, the Sponsor's address.

EMPLOYER IDENTIFICATION NUMBER AND PLAN IDENTIFICATION NUMBER

The Employer Identification Number assigned to the Trust by the Internal Revenue Service is 91-2017261. The Plan Identification Number is 551.

PLAN TRUSTEES

The name, title and address of the principal place of business of the trustees of the Plans is:

Board of Trustees of the Hanford Employee Welfare Trust
c/o Fluor Hanford, Inc.
P. O. Box 1000, MSIN: H2-25
Richland, WA 99352

PLAN ADMINISTRATOR

The designated Plan Administrator of the Plans is the Board of Trustees of the Trust. The rights, duties, powers, and authority of the Board of Trustees is described in the Hanford Employee Welfare Trust Agreement (the "Trust Agreement"). All of the Trustees are representatives of the Sponsors (including your Employer) who establish and maintain the Plans.

The name, address and telephone number of the Plan Administrator is:

Board of Trustees of the Hanford Employee Welfare Trust
c/o Fluor Hanford, Inc.
P.O. Box 1000, MSIN: H2-25
Richland, WA 99352
Attn: Dominic Sansotta, Chairman
Telephone: (509) 372-2294

PLAN ADMINISTRATOR'S DISCRETION

In carrying out its responsibilities under the Plans, the Plan Administrator has the exclusive responsibility and full discretionary authority to control the operation and administration of the Plans and to make all fiduciary decisions under the Plans, and it has all power necessary to accomplish such purposes. These powers include, but are not limited to:

- To make and enforce such rules and regulations as in its sole, absolute and uncontrolled discretion it deems necessary or proper for the efficient administration of the Plans which are not inconsistent with the terms of the Plans or the Employee Retirement Income Security Act of 1974, as amended (ERISA).

- To interpret the Plan documents in its discretion and its interpretation in good faith. Such interpretation is final and conclusive on all persons claiming benefits under the Plans.

- To use, employ, discharge or consult with one or more individuals, corporations or other entities with respect to advice regarding any responsibility, obligation or duty in connection with the Plan.

- To allocate fiduciary responsibilities by written instrument signed in the same manner as provided for delegations.

- To designate other individuals, corporations or other entities to carry out fiduciary responsibilities, obligations and duties under the Plan, and to revoke, modify or change any such delegation, revocation or modification by written instrument.

In carrying out its responsibilities, the Plan Administrator shall be fully protected to the fullest extent permitted under ERISA. In the event of any delegation in accordance with the above, no fiduciary shall be liable for any act or action, whether of commission or omission, taken by the person to whom the delegation is made. Fiduciary responsibilities shall be exercised severally and not jointly and each fiduciary's powers, duties, obligations and responsibilities shall be limited to those specifically allocated to such fiduciary or in accordance with the terms of this document.

PLAN RECORDS AND PLAN YEAR

The fiscal records for all Plans are maintained and reported on a twelve-month period of time, known as the Plan Year. The Plan Year begins on January 1 and ends on December 31.

SOURCE AND AMOUNT OF CONTRIBUTIONS

The source of contributions for each Plan is described in the Plans Chart (Attachment A). Depending on the Plan, contributions are made entirely by the participants, or partly by the Sponsors and partly by the participants. The Board of Trustees will determine, from time to time, what portion of cost of the benefits will be paid by the Sponsors and what portion will be paid by the participants. Any amounts paid by a Sponsor will be paid out of such Sponsor's general assets.

PAYMENT OF BENEFITS

How benefits are paid under each Plan (i.e., the method of payment of benefits) is described for each Plan in the Plans Chart (Attachment A). The Chart provides the name of any insurance company, trust fund or other institution, organization, or entity which maintains a fund on behalf of a Plan or through which a Plan is funded or benefits are provided.

You should read the Plans Chart to understand exactly how benefits are paid for each Plan in which you participate. However, the following provides some general background.

The primary function of the Trust is to receive and hold Sponsor and participant contributions to the Plans, to pay insurance premiums or claims under the Plans and Plan expenses, as applicable. However, the Trust is not solely responsible for payment of benefits under the Plans. Benefits may be payable by an insurance company, the Sponsors (i.e., your former Employer) or a combination of both, depending on whether the Plan is insured, self-insured or partly insured and partly self-insured.

Some of the Plans under which your benefits are provided are Insured, as described on the Plans Chart (Attachment A). **This means that only the insurance company which insures those benefits is responsible for payment of those benefits.** Your former Employer is not responsible for payment of any benefits under the Insured Plans.

Some of the Plans under which your benefits are provided are Self-Insured by the Sponsors, as described on the Plans Chart (Attachment A). **This means that only your former Employer is responsible for payment of those benefits.** Sponsors other than your former Employer are not responsible for payment of your benefits under the Self-Insured Plans.

Although Fluor may administer aspects of a Plan, it only has responsibility for payment of your benefits if Fluor is your former Employer and the Plan is Self-Insured by Fluor.

DESCRIPTION OF BENEFITS

A description or summary of the benefits for each Plan is contained in a separate SPD for each Plan. The SPD may also make reference to schedules of benefits. These SPDs are available without cost to any participant or beneficiary who so request.

ELIGIBILITY FOR BENEFITS

You are eligible to participate in the applicable Plans described in the Plans Chart (Attachment A) if you are an eligible retiree from a Plan Sponsor or former Plan Sponsor. Your dependents may also be eligible. See the discussion below. To be an eligible retiree, you must have terminated from employment (active, LTD, ROF) with your Employer at age 55 or older with 10 years of pension vesting coverage. Office and Professional Employees International Union (OPEIU) represented employees are not eligible for retiree medical coverage or life insurance coverage.

Effective January 1, 2004, newly hired employees are not eligible to participate in the group health (medical) Plans described in this document. An employee hired before January 1, 2004 with a termination date prior to January 1, 2004 who is rehired within 5 years of his or her termination date, may be eligible for benefits described in this document.

A rehired retiree, eligible for post-retirement medical coverage, retains their eligibility for post-retirement medical coverage upon re-retirement.

An otherwise eligible participant is entitled to a one-time opt out of post-retirement medical benefits. This election is available when the participant leaves employment or at a later date. After opting out, the participant may elect coverage only within 30 days following a qualifying change of status or effective as of an annual open enrollment. If coverage is dropped again for any reason, the participant may not again elect coverage.

An eligible participant must elect life insurance coverage at termination of employment. If you do not enroll for life insurance when it is first available or if you allow it to be discontinued or lapse, you may not again enroll or reinstate the coverage.

Eligible dependents are only those who were enrolled as dependents on your last day of service as an active employee, reduction-of-force, disability or other approved leave. In addition, they must meet eligibility requirements at the date you seek to enroll them (i.e., age, status, etc.). No new dependents may be added at any time.

Your dependents, as defined below, are eligible to participate only as described in the Plans Chart (Attachment A). All dependents must also meet the requirements set forth below applicable to the type of dependent. A dependent may not be enrolled in a Plan unless you are enrolled in the Plan. Except as under prior agreement, no individual may be covered more than once under the HEWT sponsored plans.

Eligible <u>dependents</u> include:

- Your legal **spouse** (as recognized by Washington State Laws), unless he or she is enrolled in one of the Plans as an employee or retiree.
- An **unmarried child or children,** as defined below:
    - A natural child,

- A stepchild residing in your home, and/or primarily dependent upon you for support and maintenance,
- A legally adopted child,
- A child placed for adoption,
- A child for whom legal guardianship, custody, or conservatorship has been awarded to you or your spouse,
- not regularly employed on a full-time basis, and
- primarily dependent upon you for support and maintenance
- under the age of 23;
- 23 or more years old, coverage can be continued if the child is a full-time student, as defined below:
    - A full-time student is a person who is enrolled in and attending, full-time, a recognized course of study or training at one of the following:
        - an accredited high school,
        - an accredited college or university,
        - a licensed vocational school, technical school, beautician school, automotive school, or similar training school.
- Full-time student status is determined in accordance with the standards set forth by the educational institution. Full-time student status ceases upon graduation or if you are no longer enrolled and attending on a full-time basis. Full-time student status continues during periods of regular vacation. Or, the child is 23 or more years old and not able to be self-supporting by reason of mental retardation or a physical handicap, provided
    - the handicap existed before age 23, and
    - the child was covered as a dependent prior to reaching age 23, and
    - the child is principally dependent on you for support, and
    - proof of the child's condition and dependence is submitted prior to the date coverage would otherwise have ended.

- We may require that the child be examined by a physician chosen by us at our cost. You may be required to continue to provide proof that the child meets the conditions of incapacity and dependency. If you do not provide proof of the child's incapacity and dependency within 30 days of request, coverage for the child will end.

A child will cease to be a Dependent upon marriage or enlistment in the military service, or employed full-time and/or eligible for any other group medical plan through their employer.

HEALTH BENEFITS

A retiree may cover a spouse and children under the same medical plan in which he or she is enrolled but only if they are covered under the Employer's medical plan for employees at the time the retiree ends recognized employment service The retiree may not add new dependents.

A retiree age 65 or older may continue coverage for his or her spouse only. Other dependents are not eligible, with one exception, as follows:

- permanently physically or developmentally disabled children, and
- continuously covered under a HEWT-sponsored medical plan for active employees, and
- the retiree is providing full support.

If you die, your covered surviving spouse and eligible dependents may continue coverage until remarriage or until coverage ends (see above).

If both you and your spouse are eligible retirees or if you are an eligible retiree and your spouse is an employee of a Sponsor eligible for coverage under a HEWT-administered medical plan, you may each separately maintain coverage in your respective category or one of you may be covered by the other as a dependent spouse. There is no coordination of benefits between any of the active and retiree Plans. In other words, you or your spouse or dependents may not receive benefits under more than one HEWT-sponsored Plan.

If both you and your spouse (or former spouse) are covered by a HEWT-sponsored medical plan, your children may be enrolled as dependents under one Plan, but not more than one Plan. Your child cannot be covered as a dependent if he or she is eligible for coverage as an employee under any Sponsor's Plan.

DEPENDENT LIFE INSURANCE

Your spouse and dependents may qualify for continued dependent life insurance. See Attachment A and the definition of "dependent" in the applicable Summary Plan Description.

DISQUALIFICATION OF BENEFITS

Circumstances under which benefits may be terminated include, but are not limited to:

- In accordance with the terms of the applicable SPD.
- The individual no longer meets eligibility requirements.
- The individual rehires as a regular employee with a Plan Sponsor.
- The required premiums are not paid.
- The Plan Sponsors terminate the plan.
- If you do not make your election for eligible coverages within 31 days prior to the first of the month following your last day worked.
- For an enrolled Dependent, when he or she no longer meets the requirements to remain an eligible dependent.
- Meets lifetime maximum.
- As a result of material misrepresentation, fraud, or omission of information in order to obtain coverage for a participant or others. For permitting the use of a plan's identification card or number by another person, or using another person's identification card or number in order to obtain benefits to which one is not entitled. In cases where a participant commits acts of physical or verbal abuse that pose a threat to the claim administrator, an insurance provider, or the plan administration or staff.

TYPE OF PLAN ADMINISTRATION

The type of administration (contract administration, insurer administration, etc.) of each Plan is described in the Plans Chart.

NAME AND ADDRESS OF AGENT FOR LEGAL PROCESS

The name and address of the agent for service of legal process for the Plans is:

Mr. Ralph Hawkins
Davis Wright Tremaine LLP
2600 Century Square
1501 Fourth Avenue
Seattle, WA 98101-4552

Legal process may also be served upon a Plan Trustee or the Plan Administrator.

PLAN DOCUMENTS

The Plan documents consist of this document, the summary plan descriptions, certificates of insurance, group insurance contracts, the Trust Agreement and the formal interpretations adopted by the Plan Administrator. Upon written request to the Plan Administrator, copies of any or all of the Plan documents will be furnished to a Plan participant or beneficiary at a nominal charge.

AMENDMENT AND TERMINATION OF THE PLANS

The Trust and the Sponsors have established the Plans with the bona fide intention and expectation that they will be continued indefinitely, but they reserve the right to terminate all or any of the Plans, in whole or in part, at any time, without liability. This includes, without limitation, the right to increase or decrease the Sponsors' contributions or the participants' contributions to all or any of the Plans, at any time, and to modify all or any part of the coverage with respect to any or all of the participants covered by a Plan or Plans. Any termination will be in accordance with the provisions of the Trust and the agreements under which the Sponsors adopted the Plans (the "Adoption Agreements"). Any amendment, modification or termination will be approved by the Trust and the Sponsors, as applicable, in accordance with the Trust Agreement, the Adoption Agreements, and the normal procedures of the Trust and the Sponsors for transacting business.

Upon termination or discontinuance of any Plan, you will not have any further rights, other than for the payment of benefits for covered losses or expenses incurred before such Plan was terminated. The amount and form of any final benefit you or your beneficiary receive will depend on the Plan Documents and the Plan Administrator's decisions.

CLAIMING BENEFITS

You or your beneficiary must file the appropriate forms to receive any benefits or to take any other action under any of the Plans, as described in the applicable SPD or certificate of insurance. Completed forms should be submitted to the appropriate entity described in the applicable SPD or certificate of insurance. Generally, you or your provider on your behalf will initiate a claim for benefits with the applicable party administering the benefit plan (the claims administrator or insurance company). Please review the SPD or certificate of insurance to determine exactly how to initiate a claim for benefits.

You must exhaust all of the claims review procedures described in the applicable SPD, certificate of insurance and this document before you are entitled to initiate a lawsuit in state or federal court. If there are no claim and/or review procedures set forth in the SPD or certificate of insurance, you may follow the procedure set forth below. In some instances, after you have exhausted your claim and appeal rights before the claims administrator or insurance company, you may be entitled to a final appeal to the Plan Administrator. Consult the applicable SPD or certificate of insurance.

APPEALING A DENIED CLAIM

Before you are entitled to bring a civil action under Section 502(a) of the Employee Retirement Income Security Act, you must exhaust all of the claims review procedures described here or in the applicable SPD or certificate of insurance.

Health Benefits

Urgent Claims

If your appeal involves an urgent claim that requires immediate action, all levels of appeal have been delegated to the claims administrator or insurance company that is responsible for paying claims. The claims administrator or insurance company's decisions are conclusive and binding. Consult the applicable SPD.

Pre-Service and Post-Service Claims – Insured Health Benefits

If your appeal involves a non-urgent claim and you are participating in an insured group health plan (currently Group Health Plans), all levels of appeal have been delegated to the insurance company that is responsible for paying claims. The insurance company's decisions are conclusive and binding. Consult the applicable Certificate of Coverage.

Pre-Service and Post-Service Claims – Self-Insured Health Plan

If your appeal involves a non-urgent claim under the self-insured health plans currently administered by United-Healthcare, and you are not satisfied with the first level appeal decision of the claims administrator or the insurance company, you have the right to request a second level appeal to the Plan Administrator. Your second level appeal request must be submitted to the Plan Administrator within 60 days from the receipt of the first level appeal decision, or, if later, within 180 days following the initial adverse benefit determination. You will be provided the following:

- The opportunity to submit written comments, documents, records and other information relating to your appeal.

- To receive upon request and free of charge reasonable access to, and copies of, all documents, records and other information relevant to your appeal.

- A review that takes into account all comments, documents, records and other information submitted by you relating to the claim without regard to whether such information was submitted or considered in the initial benefit determination.

- A review which will be conducted by the Plan Administrator that does not afford deference to the initial adverse benefit determination.

- If the appeal is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug or other item is experimental, investigational, or not medically necessary or appropriate, the Plan Administrator shall consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment.

- The Plan Administrator will identify all medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the adverse benefit determination without regard to whether the advice was relied upon.

- Any health care professional engaged for purposes of a consultation with respect to your appeal will be an individual who is neither an individual who was consulted in connection with the initial adverse benefit determination nor a subordinate of such individual.

You will receive notification of the Plan Administrator's decision on your appeal not later than 30 days after receipt by the Plan Administrator of your request for review unless the Plan Administrator determines that special circumstances (such as the need to hold a hearing) require an extension of time, in which you will be notified prior to the termination of the initial review period. Notice shall be provided to you in writing or electronically.

In the case of an adverse decision on your request for review, the notice shall:

- Specify the reason or reasons for the adverse determination.

- Provide you reference to the specific Plan provisions on which the determination is based.

- Provide you with a statement that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the review.

In the event that you are not satisfied with the disposition of your appeal, you are entitled to initiate a lawsuit under Section 502(a) of ERISA.

Pharmacy Benefit Program

If you are not satisfied with the disposition of your claim for benefits under the Pharmacy Benefit Program as administered by Express Scripts (ESI), contact ESI on 1-800-796-7518 to confirm claim denial. You have the right to one appeal to the Plan Administrator. Your appeal should be filed with the Plan Administrator within 60 days of the denial of your claim by ESI. In your letter of appeal to the Plan Administrator, include the following information:

- Patient's name and the identification number from the Prescription ID card

- The date(s) of service(s)

- Documentation from ESI denying claim
- The reason you believe the prescription should be covered under the Plan
- Any documentation or other written information to support your request

Send the written appeal and documentation to:

HEWT Benefits Administration JRS

P.O. Box 1000 (H2-23)

Richland, WA 99352

The procedures governing your appeal will otherwise be identical to those set forth at page 11 under the heading "Pre-Service and Post-Service Claims – Self-Insured Health Plan."

Life Insurance Benefits

Whenever a claim is denied, you have the right to appeal the decision. You (or your duly authorized representative) must make a written request for appeal to the Insurance Company within 60 days (180 days in the case of any claim for disability benefits) from the date you receive the denial. If you do not make this request within that time, you will have waived your right to appeal. Once your request has been received by the Insurance Company, a prompt and complete review of your claim must take place. This review will give no deference to the original claim decision, and will not be made by the person who made the initial claim decision. During the review, you (or your duly authorized representative) have the right to review any documents that have a bearing on the claim, including the documents which establish and control the Plan. Any medical or vocational experts consulted by the Insurance Company will be identified. You may also submit issues and comments that you feel might affect the outcome of the review. The Insurance Company has 60 days from the date it receives your request to review your claim and notify you of its decision (45 days, in the case of any claim for disability benefits). Under special circumstances, the Insurance Company may require more time to review your claim. If this should happen, the Insurance Company must notify you, in writing, that its review period has been extended for an additional 60 days (45 days in the case of any claim for disability benefits). Once its review is complete, the Insurance Company must notify you, in writing, of the results of the review and indicate the Plan provisions upon which it based its decision.

Eligibility – All Benefits

If you wish to appeal a determination that you are ineligible to participate in a particular benefits plan and you have exhausted all of the claim procedures described in the applicable SPD or certificate of insurance, that appeal must be addressed to the Plan Administrator. The procedure governing the appeal is identical to that set forth at page 11 under the heading "Pre-Service and Post-Service Claims – Self-Insured Health Plan."

RIGHTS UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 ("ERISA")

As a participant in the Plans, you are entitled to certain rights and protections under ERISA. ERISA provides that all Plan participants are entitled to:

- Examine without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all Plan Documents, including insurance contracts, collective bargaining agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.

- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary financial report.

In addition to creating rights for Plan participants, ERISA imposes duties upon the persons or parties who are responsible for the operation of the Plan. The persons who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your union or any other person, may discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within thirty (30) days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Pension and Welfare Benefits Administration, U.S. Department of Labor, listed in your telephone directory, or the Division of Technical Assistance and Inquiries, Pension and Welfare Benefit Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and

responsibilities under ERISA by calling the Publications Hotline of the Pension and Welfare Benefit Administration.

SPECIAL PROVISIONS APPLICABLE TO GROUP HEALTH PLANS

The following provisions apply only to Plans that are group health plans (each of which is a "Health Plan"), and shall supersede any inconsistent provisions in the Summary Plan Descriptions for Health Plans.

Qualified Medical Child Support Order

If a Health Plan receives a qualified medical child support order recognizing the right of any child of a participant to enrollment under the Health Plan, such child shall be enrolled as required under the terms of the order. Qualified medical child support orders shall be administered in accordance with procedures adopted by the Plan Administrator. You may obtain without charge a copy of such procedures from the Plan Administrator.

Death

If you die, your covered dependents may elect to continue coverage beyond your death. The election must be in writing and within 31 days after coverage would otherwise end as a result of your death. Coverage is dependent upon payment of required contributions. Coverage will end for your spouse upon his or her remarriage. Remarriage of your spouse will not render other dependents ineligible. However, coverage for other dependents will end when the dependents no longer meet the eligibility criteria to qualify as a dependent. This period of coverage will be credited toward satisfying the maximum coverage provided under COBRA discussed below.

COBRA Continuation Coverage

If you are the spouse of a retiree covered by the Health Plan, you have the right to elect COBRA continuation coverage for yourself if you lose your group health coverage under the Health Plan for any of the following qualifying events:

- The death of your spouse;
- Divorce or legal separation from your spouse; or
- Your spouse becomes entitled to Medicare benefits under Title XVIII of the Social Security Act.

A dependent child of a retiree covered by the Health Plan has the right to elect COBRA continuation coverage if the dependent child's group health coverage under the Health Plan is lost for any of the following qualifying events:

- The death of the employee-parent;

- The parents' divorce or legal separation;

- The employee-parent becomes entitled to Medicare benefits under Title XVIII of the Social Security Act; or

- The dependent ceases to be a "dependent child" under the Health Plan.

Electing COBRA Continuation Coverage.

The Plan will offer COBRA Continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. The covered retiree or a covered family member has the responsibility to provide written notice of the retiree's divorce or legal separation, or a child losing dependent status under the Plan. This written notice must be provided to the Plan Administrator (as described below) within 60days after the later of (1) the date of such an event, or (2) the date on which the affected retiree or family member would otherwise lose coverage because of such event. If this notice is not given to the Plan Administrator within the required 60-day period, the affected retiree or family member will not be entitled to elect COBRA continuation coverage.

If a covered retiree or covered family member provides notice of the retiree's divorce or legal separation, or a child losing dependent status under the Plan, and COBRA continuation coverage is not available, the retiree or covered family member will be notified by the Plan Administrator that COBRA continuation coverage is not available.

The Employer has the responsibility to notify the Plan Administrator of the retiree's death, or the retiree becoming entitled to Medicare under Title XVIII of the Social Security Act.

When the Plan Administrator is notified that one of these qualifying events has occurred, the Plan Administrator will in turn notify the appropriate individuals (also called "qualified beneficiaries") that they have the right to elect COBRA continuation coverage. COBRA continuation coverage must be elected by such individuals within sixty (60) days after the later of (1) the date that coverage under the Health Plan would otherwise terminate due to the qualifying event, or (2) the date that these individuals are provided with written notification of their right to elect COBRA continuation coverage. If COBRA continuation coverage is not elected within this 60-day period, the Health Plan coverage will end retroactive to the date that coverage would have otherwise ended due to the COBRA qualifying event, and the affected family member will not be entitled to elect COBRA continuation coverage. While an election by a covered spouse will be treated as an election of COBRA continuation coverage by the entire family, each family member may make a separate election as to COBRA continuation coverage. This means that a covered spouse or dependent child may separately elect COBRA continuation coverage. A covered spouse or dependent may elect COBRA continuation coverage even if covered under another group health plan or Medicare prior to electing COBRA continuation coverage.

Duration of Coverage.

If continuation of coverage is elected, the Health Plan is required to provide COBRA continuation coverage which, at the time that coverage is being provided, is identical to the coverage provided under the Health Plan to similarly situated Health Plan participants who have not experienced a qualifying event (called "non-COBRA beneficiaries"). For example, if a retiree dies leaving a spouse and two dependent children covered under the Health Plan, they would be entitled to the same benefits as the covered spouse and dependent children of a retiree. If the benefits for similarly situated non-COBRA beneficiaries are modified, the changes will apply to those who have COBRA continuation coverage as well.

COBRA continuation coverage may be maintained for up to 36 months.

In general, your covered dependents (if any) will only be given an opportunity to continue the coverage they were receiving immediately before the qualifying event. In a few circumstances, however, they may elect alternative coverage that the Plan makes available to retirees, such as:

(1) If you participate in a region-specific HMO that will not service your health needs in the area to which you are relocating, you must be given an opportunity to elect alternative coverage that the employer makes available to active employees.

(2) You and your covered dependents (if any) will have the same opportunity as a retiree to change your coverage at open enrollment.

When COBRA Continuation Coverage Ends.

The law provides that COBRA continuation coverage will be cut short for any of the following reasons:

(1) Your former Employer no longer provides group health coverage to any of its employees;

(2) The premium for the COBRA continuation coverage is not paid on a timely basis (the first premium payment is payable in a lump sum forty-five (45) days after electing COBRA continuation coverage; all subsequent premium payments are payable within thirty (30) days after the due date);

(3) The covered individual first becomes, after the date of the COBRA continuation coverage election, covered under another group health plan (as an employee or otherwise) that does not contain any exclusion or limitation with respect to any pre-existing condition of that individual (other than an exclusion or limitation that does not apply to, or is satisfied by, such individual by reason of the Health Insurance Portability and Accountability Act of 1996);

(4) The covered individual first becomes, after the date of the COBRA continuation coverage election, entitled to Medicare (under Title XVIII of the Social Security Act); or

(5) Upon the occurrence of any event (such as submission of fraudulent claims) by a covered individual that permits termination of Health Plan coverage for cause with respect to similarly situated non-COBRA beneficiaries.

Covered individuals should provide written notice to the Plan Administrator if an event occurs that is listed in number (3) or (4) above within thirty (30) days after becoming eligible for such other group health plan coverage or entitled to Medicare.

Cost of Coverage.

The cost of COBRA continuation coverage will generally not exceed 102% of the cost for coverage under the Health Plan. The cost of COBRA continuation coverage will increase in the middle of the 12-month determination period only in the following instances:

(1) where the qualified beneficiary changes to more expensive coverage, or

(2) where the Health Plan was previously requiring payment of less than the maximum permissible amount.

An individual seeking COBRA continuation coverage is liable for the cost of that coverage during the entire applicable 36-month period (measured from the date that coverage would otherwise end due to the qualifying event). Due to the required sixty (60) day COBRA election period, it is likely that a covered individual will be responsible for retroactive premiums. These premiums must be paid in a lump sum within forty-five (45) days after electing COBRA continuation coverage in order for the COBRA continuation coverage to be effective. After that payment, premiums are due on a monthly basis. Coverage will terminate if premiums are not paid within thirty (30) days after the date they are due.

An individual need not show proof of insurability to elect COBRA continuation coverage.

Effect of COBRA Continuation Coverage on Other Rights Under Federal Law.

In considering whether to elect continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under federal law. First, you may lose the right to avoid having preexisting condition exclusions applied to you by other group health plans. If you have more than a 63-day gap in health coverage, an election of continuation coverage may help you not to have such a gap. Second, you will lose the guaranteed right to purchase individual health insurance policies that do not impose such preexisting condition exclusions if you do not get continuation coverage for the maximum time available to you. Finally, you should take into account that you may have special enrollment rights under federal law. You have the right to request special enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer) within 30 days after your group health coverage ends because of a qualifying event listed above. You will also have the same special enrollment right at the end of continuation coverage if you get continuation coverage for the maximum time available to you.

Coverage Expires.

When COBRA continuation coverage expires after 36 months, an individual has the opportunity to enroll in an individual conversion health plan provided by the Health Plan if such option is otherwise generally available to similarly situated non-COBRA beneficiaries under the group health plan.

If You Have Questions.

Questions concerning your health plan or your COBRA continuation rights should be addressed to the Plan Administrator. For more information about your rights under ERISA, including COBRA and other laws affecting group health plans, contact the nearest regional or district office of the U.S. Department of Labor's Employee Benefit Security Administration (EBSA), or visit the EBSA website at www.dol.gov/ebsa.

Notices to the Plan Administrator.

Any notices that a retiree or covered family member must make to the Plan Administrator (including notice of the retiree's divorce or legal separation, or a child losing dependent status) should be delivered to the following address:

Benefits Administration
c/o Fluor Hanford, Inc.
P.O. Box 1000, MSIN: H2-23
Richland, Washington 99352-1000
Attn: COBRA Administrator

When providing notification to the Plan Administrator of the retiree's divorce or legal separation, or a child losing dependent status, you must complete a COBRA eligibility Request Form. The COBRA Eligibility Request Form is available from Benefits Administration.

Address Changes.

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy for your records of any notices you send to the Plan Administrator.

Newborns' and Mothers' Health Protection Act of 1996

For Insured Plans that provide maternity or newborn infant coverage, special rights upon childbirth under the Newborns' and Mothers' Health Protection Act of 1996, as amended, and state law, as applicable, are described in the SPDs for the applicable Insured Plan. For Self-Insured Plans that provide maternity or newborn infant coverage, special rights upon childbirth are described below:

Special Rights Upon Childbirth: Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with

childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Privacy

The health plan is required by law to protect the privacy of certain health information that it may use or disclose. Retirees will be provided with a Notice of Privacy Practices within 90 days of enrollment in the health plan that describes how the health plan may use or disclose your health information, your rights with respect to your health information, and the health plan's duties with respect to your health information. To get a copy of the notice, or if you have questions regarding the protection of your health information, you may contact the Health Plan Privacy Officer at (509) 376-1524.

Attachment A

PLANS CHART

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
1. HEWT "Options PPO" Plan for Retirees This Plan covers retired employees who are under age 65 and their eligible dependents. See Eligibility Section. Plan No. 551	Health, mental health and substance abuse benefits. Claims Administration (except Prescription Drugs) by United Healthcare. Prescription Drugs benefits administered by Express Scripts, Inc.	Sponsors Participants	Self-insured by your Sponsor (i.e., benefits are paid from retiree contributions, if any, and the Sponsor's general assets) and are funded through the Hanford Employee Welfare Trust (HEWT). United Healthcare provides administrative services only for health benefits. Express Scripts, Inc., provides administrative services only for retail and mail order prescription drug benefits. United Healthcare's address is: P.O. Box 30555 Salt Lake City, UT 84130-0555 Express Script's address is: P.O. Box 390873 Bloomington, MN 55439

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
2. HEWT "Medical Plan for Medicare-Eligible Retirees" This Plan covers retired employees who are age 65 or older and their eligible dependents. See Eligibility Section. Plan No. 551	Health, mental health and substance abuse benefits. Claims Administration (except Prescription Drugs) by United Healthcare. Prescription Drugs benefits administered by Express Scripts, Inc.	Sponsors Participants	Self-insured by your Sponsor (i.e., benefits are paid from retiree contributions, if any, and the Sponsor's general assets) and are funded through the Hanford Employee Welfare Trust (HEWT). United Healthcare provides administrative services only for health benefits. Express Scripts, Inc., provides administrative services only for retail and mail order prescription drug benefits. United Healthcare's address is: P.O. Box 30555 Salt Lake City, UT 84130-0555 Express Script's address is: P.O. Box 390873 Bloomington, MN 55439

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
3. Group Health Cooperative (GH) HMO Plan This plan covers retirees who are under age 65 and not eligible for Medicare Plan No. 551	Provides health, vision, prescription drug and mental health and substance abuse benefits. Insurer administration	Sponsors Participants	Insured GH insures benefits through an insurance policy. It also administers the plan, including payment of claims. GH's address is: Group Health Cooperative 1009 Center Parkway Kennewick, WA 99336
4. Group Health Cooperative (GH) HMO Plan This plan covers retirees who are over age 65 and eligible for Medicare A and B. Plan No. 551	Same as 3, above.	Same as 3, above.	Same as 3, above.
5. Group Health Cooperative (GH) "Options" Point of Service Plan This plan covers retirees who are under age 65 and not eligible for Medicare Plan No. 551	Same as 3, above.	Same as 3, above.	Same as 3, above.

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
6. Group Health Cooperative (GH) "Options" Point of Service Plan for Medicare-Eligible Retirees This plan covers retirees who are over age 65 and eligible for Medicare A and B. Plan No. 551	Same as 3, above.	Same as 3, above.	Same as 3, above.
7. Basic Life/AD&D Plan Basic Life covers all retirees. AD&D covers retirees until age 65. Plan No. 551	Provides life and accidental death and dismemberment benefits. Insurer administration	Sponsors Participants	Insured CIGNA insures the benefits through an insurance policy. It also administers the plan. CIGNA's administrative services include: claim administration, cost containment, financial, banking, billing administration and payment of claims. CIGNA's address is: Life Insurance Company of North America 1601 Chestnut Street Philadelphia, PA 19192-2235

Plan Name, Number and Participants	Plan Type and Type of Administration	Sources of Contributions	Payment of Benefits
8. Dependent Life Insurance Plan This is available to retirees under age 65, only.	This provides dependent life insurance benefits. Insurer administration	Participants	Insured Same as 8, above

Attachment B

SPONSORS CHART

Name of Sponsor	Employer Identification Number	Address
Fluor Hanford , Inc.	33-0691003	P.O. Box 1000, H2-23 Richland, WA 99352
Bechtel Hanford, Inc	94-3171284	3070 George Washington Way Richland, WA 99352
CH2M HILL Hanford Group, Inc.	91-1733503	P.O. Box 1500 Richland, WA 99352
Protection Technology Hanford	23-2743219	979 Snyder/2505A Richland, WA 99352
Numatec Hanford Corp.	52-1990958	2425 Stevens Center Circle Richland, WA 99352
Johnson Controls, Inc.	39-0380010	P.O.Box 750 Richland, WA 99352
Duratek Federal Services of Hanford, Inc.	36-4066233	P.O. Box 700 Richland, WA 99352
Energy Northwest	91-6018049	P.O. Box 968 Richland, WA 99352
CH2M HILL Hanford, Inc	84-1266814	3190 George Washington Way Richland, WA 99352
Parsons Fabricators Hanford, Inc.	20-0561678	3005 East Ainsworth St. Warehouse S Pasco, WA 99301
Eberline Services Hanford, Inc.	91-1688187	3350 George Washington Way Richland, WA 99352